

gastric retention ensues though evidence of pre-operative pyloric obstruction has been lacking. It is becoming increasingly apparent that vagotomy alone is not the treatment of choice in the surgical management of duodenal ulcer. In an occasional uncomplicated case in a young individual in whom the neurogenic features are striking and in whom gastric resection seems undesirable for various reasons, vagotomy alone may be indicated. However, for most experienced surgeons this group is gradually narrowing and may well eventually disappear.

What about vagotomy in the management of gastro jejunal ulcer? It is in this group of cases that the operation seems to be of the greatest value. The difficulty and lack of success of medical therapy, the considerable risk and occasional impossibility of further gastric resection and the likelihood of recurrence of the lesion make the usual forms of therapy for this condition rather unsatisfactory. Vagotomy can be carried out in such cases with little risk and, since the problem of postoperative gastric retention usually is non-existent because of the previously made anastomosis, this procedure seems indicated.

Should vagotomy be done by surgical approach from above or below the diaphragm? The advantage of the infradiaphragmatic approach is that the lesion in the stomach or duodenum can be observed and be dealt with if necessary at one operation. The disadvantage is that there may be difficulty in completely resecting all of the fibres of the vagus nerves. On the other hand, the supradiaphragmatic approach is simple and permits section of the vagus nerves above the level where they branch into a network and more certainly leads to complete vagotomy. However, the disadvantage of the approach is that it does not permit inspection of the lesion and a second operation may be necessary if uncontrollable gastric retention develops. Moreover in some cases severe postoperative intercostal pain persists for weeks to months. More and more surgeons are using the abdominal approach and it seems that the advantages of this method are the greater.

Finally, should vagotomy be done as a secondary

procedure following gastric resection (or gastroenterostomy or pyloroplasty) for ulcer? The answer to this question is not known. It will be a long time before sufficient information has been collected properly to evaluate the results of partial gastrectomy and vagotomy as compared to those of partial gastrectomy alone in the treatment of duodenal ulcer. To a greater extent the answer depends on the ultimate effects of vagotomy on the human stomach, and these are completely unknown. We shall have to wait at least ten years if not longer and have studies of large numbers of carefully controlled and collected cases before establishing or rejecting this combined surgical procedure.

In some way, then, many problems remain to be settled in the use of this most interesting procedure. As it stands now, it appears that simple vagotomy should not be done for gastric ulcer, that it is rarely indicated as a single surgical procedure for duodenal ulcer, that the field of greatest usefulness for it is in the treatment of marginal and jejunal ulcer, and that the usefulness of it as an adjunct to operations resulting in a new gastric stoma remains to be established.

Here then is a simple procedure the results of which cannot be clearly defined or delineated because we have so little knowledge of the ultimate results of section of nerves as large and complex as the vagi.

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## Democracy Prevails Again

If there had been any question prior to the 1947 Annual Session about the prevalence of democracy in the California Medical Association, that question was thoroughly resolved by the events of the session. If there were any doubts on this score, they may be eliminated.

As proof of the democratic process at work, twenty-nine resolutions and five proposed constitutional amendments were placed before the House of Delegates. Some of this material represented group presentations from county delegations and some came in the form of emanations from individual members of the House. All were freely offered and fully considered. Each was given its

own hearing before a reference committee and the report of the committee on each item was subject to free debate on the floor.

True, some of the resolutions sought to change the policies or operating procedures of the Association. Some offered criticism, constructive or otherwise, and some proposed that new fields of endeavor be explored. Taken all in all, the resolutions constituted a cross-section of the thinking of the medical profession of the state, offered without fear or favor.

From the deliberations of the House of Delegates, two major factors emerged. First, the policies of the Association and its Council were affirmed by

the Delegates; the course taken by the guiding officers was approved. Inasmuch as the Council has the authority and the obligation to manage the affairs of the Association between the meetings of the House of Delegates, this constituted a vote of confidence in the actions and policies of the Council. Secondly, the House voted for the exploration of an internally-operated public relations program, aimed principally at improving the relationships between individual physicians and their individual patients.

The ramifications of this second item are manifold and varied. The possibilities appear unlimited. Fundamentally, the objective of such a program would be to cement the profession more closely to

the public, to assure a feeling on the part of the public that the profession is doing its job humanely as well as scientifically. With the public holding such a feeling, it seems obvious that public clamor for radical changes in the control of the practice of medicine would diminish if not cease completely. If that eventuates, the crises which have plagued the profession in the form of punitive or control legislative proposals might well vanish.

These are but two examples of the results of the House of Delegates deliberations. In addition, numerous technical matters were decided, again after full consideration, open debate and free speech. Thus is the medical profession of California served and the principles of democracy maintained.

## Diagnostic Medical Care and Lay Laboratories

The great importance of accurate diagnosis in modern medical care is now well known. An accurate history and a correct and complete physical examination properly interpreted are the cornerstones of medical diagnosis. Supplemental clinical laboratory and radiological examinations are necessary diagnoses in many cases. Following these additional diagnostic studies, still further tests (such as bronchoscopy, cystoscopy, gastroscopy) are required in a very small number of cases.

Diagnostic medical examinations which involve clinical laboratory work, pathology and radiology may be done in the individual doctor's office, in office medical buildings and in hospitals. The fundamental part of the examination is the availability of trained personnel in order that it may be conducted properly and interpreted adequately. In the larger centers, radiologists and pathologists (qualified M.D.'s) normally perform such functions. In the smaller communities, circumstances often require that they be performed by general practitioners who have had some supplemental training in radiology or pathology.

The profound importance of competent pathological examination is evidenced in the early diagnosis of malignant disease. Take the common example of a woman with a lump in her breast or the young male with a painful bone lesion. In either case, the process may be neoplastic. If it is, the swiftest method of cure is removal of the breast or leg. Upon whose decision and diagnosis must this grave step often be taken? Upon the pathologist's. If there is a well trained pathologist accessible to the hospital or medical building, the patient is apt to receive a correct diagnosis and a life saving measure then justifiably undertaken. On the other hand, if reliance is placed upon a poorly trained person or one not well grounded in medicine, needless and mutilating operations may be performed for benign tumors or an unnecessary delay may occur in the treatment of malignant lesions. If a diagnostic procedure such as a blood count or a chest x-ray is performed by competent

personnel responsible to and under the supervision of a specialist in one of those fields, the end result is apt to be earlier diagnosis and better medicine. A poorly done test is often worse than none at all.

In the early days of clinical laboratory and radiological medicine, it was not unusual for technicians (notably after World War I) to set themselves up as practitioners in these fields. Many of them were moderately experienced, and most were well intentioned. Owing to the shortage of trained medical specialists, these laymen were accepted and supported by the profession at large. In the meantime, departments of radiology and clinical pathology were becoming established in medical schools, and young physicians were being encouraged by the faculties to enter these fields. Today, if we are to encourage the continued development of such competent specialists, we must face the fact that any further development of lay laboratories will be completely deterrent.

In some parts of the country, the lay laboratory has become synonymous with convenient diagnoses and even rebates. To the credit of the medical profession is the fact that such practices are exceptional. Nevertheless, the handwriting is on the wall, and the signs are clear. We must begin to support our medical laboratories, owned and conducted by medical men trained in their fields, and not lend aid to laymen attempting to invade the practice of medicine.

When the existing and accepted lay laboratories pass from their original hands, it is to be trusted that the practice will become as obsolete as the barber surgeon. Not so many years ago, all surgery was done by technicians or barbers; the medical profession condoned this. Then, after further study and especially after the development of antisepsis and anesthesia, matters changed and were gradually corrected. It would now seem to be appropriate to hasten similar constructive evolution of the lay laboratory (whether it be in a medical building or a hospital building).